STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155790		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2012		
	PROVIDER OR SUPPLIER D TRANSITIONAL (CARE AND REHAB-BRIDGEWATE	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COM	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I	DATE
F0000	This visit was f Complaint IN00 Complaint IN00 Substantiated. deficiencies rel are cited at F 1 Survey dates: Facility numbe Provider numb AIM number: Survey team: Tammy Alley, I Census bed tyl SNF: 46 SNF/NF: 40 Total: 86 Census payor Medicare: Medicaid: Other: Total: Sample: 3 These deficien	or the Investigation of 0118496. 0118496 - Federal/state ated to the allegations 57, F 282 and F 309. December 3, 4, 2012 r: 012548 er: 155790 201023760 R.N.	F00		This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilitation-Bridgewater for recent complaint survey dated 12/4/2012. Kindred-Bridgewater asserts the all corrections described on the Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of action The staff of Kindred-Bridgeward is committed to delivering high quality health care to its resident to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit Kindred-Bridgewater is in substantial compliance as set forth below, we are confident to it will be found in substantial compliance with regulations up re-survey. The statements made on the post of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. Further, we are requesting a direview for all 3 deficiencies as they were not widespread issuand had contained no harm.	of the hat is e tion. ter ents hat boon blan he tesk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155790	A. BUILD B. WING	ING	NSTRUCTION 00	(X3) DATE COMPL 12/04/	ETED		
KINDRE		CARE AND REHAB-BRIDGEWAT	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	Quality review Williams, RN	12/05/12 by Suzanne							

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Event ID: VWQU11

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155790		A. BUI	LDING	00	(X3) DATE (COMPL 12/04 /	ETED
		133730	B. WIN			12/04/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE CAREY RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-BRIDGEWATE	ĒR		EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157 SS=D	resident; consult physician; and if I legal representation member when the the resident which the potential for reintervention; a significantly (i.e., a deteor psychosocial streatening condicomplications); a significantly (i.e., existing form of the consequences, of treatment); or a discharge the respecified in §483. The facility must be representative or when there is a commate assign §483.15(e)(2); or under Federal or specified in paragonal modern the resident's legal interested family based on reconsistent in the facility must be update the address the resident's legal interested family based on reconsistent in the facility must be update the address the resident's legal interested family based on reconsistent interview, the facility when the facility must be update the address the resident's legal interested family based on reconsistent interview, the facility when the facility must be update the address the resident's legal interested family based on reconsistent interview, the facility must be update the address the resident's legal interested family based on reconsistent interview, the facility must be update the address the resident's legal interested family based on reconsistent interview, the facility must be update the address the resident's legal interested family based on reconsistent interview.	mediately inform the with the resident's known, notify the resident's ve or an interested family ere is an accident involving in results in injury and has equiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, tatus in either life tions or clinical need to alter treatment a need to discontinue an eatment due to adverse reducision to transfer or ident from the facility as 12(a). Also promptly notify the nown, the resident's legal interested family member hange in room or ment as specified in a change in resident rights State law or regulations as graph (b)(1) of this section.	F01	57	F157 The facility immediately informs the resident; consult with the resident's physician	t	12/17/2012
	blood sugars a physician, for 1	s ordered by the of 3 residents			and if known, notify the resident's legal representative when there are orders to not		

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPLE	ETED
		155790	A. BUI B. WIN	LDING		12/04/2	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CAREY RD		
KINIDREI	TRANSITIONAL (CARE AND REHAB-BRIDGEWATI	ER.		EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	<u> </u>	TAG		,	DATE
		hysician notification in a			physician of certain low and		
	sample of 3. (Resident B)			high blood sugar readings, a		
					has the potential for requiring physician intervention. 1.	ig	
	Findings Includ	de:			Resident B had accu checks		
					performed during stay befor		
	The record for	Resident B was			and after the named date wh		
	reviewed on 12	2/3/12 at 7:11 a.m.			physician was notified for		
					blood sugars out of		
	Current diagno	ses included, but were			parameters, and then was		
	not limited to, diabetes. Physician orders dated 9/7/12				examined by a physician,		
					whom addressed. 2. All oth	er	
					residents who might be		
					affected were identified		
	indicated to ca	II the physician if the			through audit and reporting	of	
		d sugar was less than			diabetic diagnosis and call orders on blood sugar result	te:	
		•			baseline data identified and		
	70 at the 2-3 a	.m., accucheck.			other issues noted. 3.		
					Licensed nursing staff were		
	The nursing no	otes for 9/22/12			in-serviced by the Staff		
		esident's blood sugar at			Development Coordinator		
		-			(SDC) by 12/14/12 regarding		
	•	. The resident was			informing physicians of		
	alert and reque	ested a coke. His blood			resident's condition as it	_	
	sugar was rech	necked and came up to			relates to call orders of bloo		
	65. No physic	ian notification was			sugar results. 4. Daily rando observation and monitoring		
	located.				done by the Nursing	15	
	located.				Management team, through		
					auditing with audit tools and	ı	
	On 12/3/12 at	10 a.m., additional			daily rounding of patients ar		
	information wa	s requested from the			units to insure that staff is		
	Director of Nur	sing regarding the lack			notifying physicians in rega	rds	
		otification of low blood			to blood sugar call orders.		
	' '	Ameauon or low blood			Negative results from this		
	sugar.				monitoring are taken throug	n	
					the Quality Improvement	ion	
	On 12/3/12 at	10:50 a.m., the Director			process monthly. 5. Complete Date: 12/17/12 Desk Review	IIUII	
		•			requested.		

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155790	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 4/2012
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-BRIDGEWATE	14751 (ADDRESS, CITY, STATE, ZIP CO CAREY RD EL, IN 46033	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	of Nursing indicated she was unable to provide any additional information regarding physician notification.				
	This federal tag relates to complaint IN00118496.				
	3.1-5(a)(2)				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLE	ETED
		155790	B. WIN		·	12/04/2	2012
NAME OF B	AD CHARLED OR CHARLIED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIER	L		14751 (CAREY RD		
KINDRE	O TRANSITIONAL (CARE AND REHAB-BRIDGEWAT	ER	CARME	EL, IN 46033		
(X4) ID		MARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG F0282		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
SS=D	CARE PLAN The services proving facility must be proving the provin	UALIFIED PERSONS/PER vided or arranged by the rovided by qualified dance with each resident's					
	written plan of ca	re.					
	Based on reco		F02	82	F282		12/17/2012
		acility failed to ensure			The services provided or		
	_	ere obtained as the			arranged by the facility are provided by qualified person	_	
		red for 3 of 3 residents			in accordance with each	•	
		ood sugar results in a			resident's written plan of car	e.	
	sample of 3. (F	Resident B, C, and D)					
	Findings includ				Resident B received accu checks before and after the named dates until his planne discharge home from facility		
		for Resident B was			Resident C received accu		
		2/3/12 at 7:11 a.m.			checks before and after the		
	Current diagno	ses included, but were			named dates through presen	it.	
	not limited to, o	liabetes.			Resident D received accu checks before and after the		
					named dates until his		
	Current physici	ian orders indicated the			discharge from the facility.		
		have an accucheck			2. All other residents who		
		nes daily. On the			might be affected were	_	
	·	•			identified through auditing a		
	_	and times the diabetic			diagnosis reports for diabeti patients; baseline data	ic	
		ed accucheck results:			identified without further		
	10/24/12 at 3 a	ı.m.			issues.		
	10/25/12 at 3 a	ı.m.			3. Licensed nursing staff wer		
	10/12/12 at 3 a	ı.m.			in-serviced by 12/14/12 on the		
					above patients by the SDC as		
	On 12/3/12 at 1	10 a.m., additional			well as other diabetic patient and the accu check orders a		
		·			policy.		
		s requested from the			4. Daily random observation		
	Director of Nurs	sing regarding the			and monitoring is done by th	e	
					Nursing Management team,		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155790	B. WIN			12/04/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	ę.		14751 (CAREY RD	
KINDRE	O TRANSITIONAL (CARE AND REHAB-BRIDGEWATE	ER	CARME	EL, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	above blood su	ugar results.			through auditing with audit tools and daily rounding of	
					patients and units to insure	
	On 12/3/12 at 10:50 a.m., during an interview with the Director of Nursing				that staff is following physici	an
					orders regarding accu check	
	she indicated s	she was unable to			and the written plans of care	
	provide any ad	lditional information			Negative results from this	
	regarding the a	above accucheck			monitoring are taken through	1
	results.				the Quality Improvement process monthly.	
					5. Completion Date: 12/17/12	
	2. The record for Resident C was reviewed on 12/3/12 at 9:06 a.m. Current diagnoses included, but were not limited to, diabetes.				Desk review requested	
		alabetee.				
	The diabetic flo	ow sheet lacked				
	accucheck res	ults on the following				
	dates and time	es:				
	10/31/12 at 11	a.m.				
	11/2/12 at 11 a	a.m.				
		••••				
	On 12/4/12 at	8:23 a.m., additional				
	information wa	s requested from the				
	Director of Nur	sing regarding the				
	above blood su					
	2.20.000000	-g-: 100a.to.				
	On 12/4/12 at 9	9:15 a.m., the Director				
	of Nursing indi	cated she had no				
	l	mation to provide				
		above accucheck				
	•	above accucitect				
	results.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155790	B. WIN	IG		12/04/2012
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE	
KINDREI	TRANSITIONAL (CARE AND REHAB-BRIDGEWA	TER	1	CAREY RD EL, IN 46033	
			1	ID	,	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	3. The record	for Resident D was				
	reviewed on 12	2/3/12 at 9:50 a.m.				
	_	oses included, but were				
	not limited to, o	ulabetes.				
	Current physic	ian orders indicated an				
		the resident's blood				
	sugar twice da	ily. Original date of the				
	order was 3/22					
	The diabetic flo	ow sheets on the				
	following dates	s and times lacked a				
	blood sugar re					
	9/6/12 at 4 p.m					
	9/11/12 at 7 a.	m.				
	9/14/12 at 7 a.	m.				
	9/18/12 at 7 a.	m.				
	10/8/12 at 4 p.	m.				
	10/10/12 at 4 p	o.m.				
	10/22/12 at 7 a	a.m. and 4 p.m.				
	10/26/12 at 4	p.m.				
	10/27-28/12 at	7 a.m. and 4 p.m.				
	(10/27/12 at 4	p.m. ok)				
	10/29/12 at 4 p	o.m.				
	11/2 /12 at 4 p	.m.				
	11/11/12 at 7 a	a.m. and 4 p.m.				
	11/15/12 at 7 a	a.m.				
	11/19/12 at 7 a	a.m.				
	11/21/12 at 7 a	a.m. and 4 p.m.				
	11/24/12 at 4 p	o.m.				

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	OF CORRECTION IDENTIFICATION NUMBER: 155790	(X2) MULTIPL A. BUILDING B. WING	00 00	COMP	E SURVEY PLETED 4/2012
KINDRE	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-BRIDGEWATI	STRI 147 ER CAI	EET ADDRESS, CITY, STATE, ZI '51 CAREY RD RMEL, IN 46033	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO TE	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	On 12/3/12 at 10:30 a.m., additional information was requested from the Director of Nursing regarding the above blood sugar results. On 12/3/12 at 11:19 a.m., she indicated she had no additional information to provide regarding the above blood sugar results. This federal tag relates to complaint IN00118496. 3.1-35(g)(2)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155790	B. WING			12/04/	2012
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER			14751 (CAREY RD		
KINDRED	TRANSITIONAL (CARE AND REHAB-BRIDGEWATE			EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0309 SS=D	483.25 PROVIDE CAREA HIGHEST WELL Each resident mu must provide the services to attain practicable physic psychosocial well the comprehensiv care. Based on recor interview, the fa administer slidi physician had or residents reviev insulin administ 3. (Resident B Findings includ The record for reviewed on 12 Current diagno not limited to, of Admission orde indicated a 2 a be completed t scale insulin wa 71-110=2 units 171-200=4 unit 226-250=6 unit	SERVICES FOR BEING st receive and the facility necessary care and or maintain the highest cal, mental, and -being, in accordance with re assessment and plan of rd review and acility failed to ng scale insulin as the ordered for 1 of 2 wed for sliding scale tration in a sample of) e: Resident B was 2/3/12 at 7:11 a.m. ses included, but were	F030		F309 The facility ensures that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, a psychosocial well-being, in accordance with the comprehensive assessment at plan of care. 1. Resident B had received the necessary care and services to attain or maintain his highest state of well-being. Staff administered sliding scale insurper physician orders before an after the dates listed. 2. All other residents who have sliding scale insulin orders are risk and are potentially affected by the alleged deficient practice of failure to provide sliding scale insulin per physician orders. These residents were identified through auditing and diagnosti reports and baseline data was obtained with no furter issues. This is included in the in-service ducation being completed at center.	nd nd ne o ullin id ve a e at d ee at d ee de	12/17/2012
	326-350=9 unit	S.			3.Licensed staff was in-servi		
					by 12/14/12 on providing quali	ty	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER IXINJI D SUMMARY STATEMENT OF DEPICIENCIES PREFIX TAG The diabetic flow sheet indicated the residents blood sugar results were in the range to receive sliding scale insulin on the following dates and times: 9/13/12 at 2 a.m., blood sugar was 76 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 72 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. Physician orders to residents purity of care with regards to sliding scale insulin orders is randomly observed and monitored daily by the Nursing management team, this is performed through auditing via use of audit tools and daily rounds on unit. Negative results from this monitoring are taken through the Quality Improvement process monthly. Completion date: 12/17/12desk review requested 11. COMPLETION 12. COMPLETION 12. ARBELLANGE AND SCARMEL, IN 46033 12. COMPLETION 12. ARBELL IN 46033 12. COMPLETION 12. ARBELLANGE AND SCARMEL, IN 46033 12. COMPLETION 12. COMPLET	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ULTIPLE CO	NSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER (X4) ID PREFIX TAG The diabetic flow sheet indicated the residents blood sugar results were in the range to receive sliding scale insulin on the following dates and times: 9/13/12 at 2 a.m., blood sugar was 76 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. Physician orders dated 9/18/12 indicated sliding scale insulin coverage was administered, should have been 2 units. Physician orders dated 9/18/12 indicated sliding scale insulin coverage was administered, should have been 2 units. Physician orders dated 9/18/12 indicated sliding scale insulin coverage was administered, should have been 3 units. Physician orders dated 9/18/12 indicated sliding scale insulin coverage was administered, should have been 3 units. Physician orders dated 9/18/12 indicated sliding scale insulin coverage was administered, should have been 3 units.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
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CAMMEL, IN 46033 CARMEL, IN 46033 CAMMEL, IN	NAME OF P	PROVIDER OR SUPPLIER	1					
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PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) The diabetic flow sheet indicated the residents blood sugar results were in the range to receive sliding scale insulin on the following dates and times: 9/13/12 at 2 a.m., blood sugar was 76 and no coverage was administered, should have been 2 units. 9/14/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 72 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. Physician orders dated 9/18/12 indicated sliding scale insulin coverage at 3 a.m., as follows: 70-120-5 units, 121-160-1 unit. 9/19/12 at 2 a.m., blood sugar was 116 and no coverage was administered, should have been 1.5	(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	1	ID		1	(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The diabetic flow sheet indicated the residents blood sugar results were in the range to receive sliding scale insulin on the following dates and times: 9/13/12 at 2 a.m., blood sugar was 76 and no coverage was administered, should have been 2 units. 9/14/12 at 2 a.m., blood sugar was 89 and no coverage was administered, should have been 2 units. 9/15/12 at 2 a.m. blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 72 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. Physician orders dated 9/18/12 indicated sliding scale insulin orders is randomly observed and monitored daily by the Nursing management team, this is performed through auditing via use of audit tools and daily rounds on unit. Negative results from this monitoring are taken through the Quality in provement process monthly. Completion date: 12/17/12desk review requested					PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	` ′
The diabetic flow sheet indicated the residents blood sugar results were in the range to receive sliding scale insulin on the following dates and times: 9/13/12 at 2 a.m., blood sugar was 76 and no coverage was administered, should have been 2 units. 9/14/12 at 2 a.m. blood sugar was 111 and no coverage was administered, should have been 2 units. 9/15/12 at 2 a.m. blood sugar was 89 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 72 and no coverage was administered, should have been 2 units. 9/17/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. Physician orders dated 9/18/12 indicated sliding scale insulin orders is randomly observed and monitored daily by the Nursing management team, this is performed through auditing via use of audit todal by trounds on unit. Negative results from this monitoring are taken through the Quality Inprovement process monthly. Completion date: 12/17/12desk review requested 11 and no coverage was administered, should have been 2 units. 9/16/12 at 2 a.m., blood sugar was 82 and no coverage was administered, should have been 2 units. Physician orders dated 9/18/12 indicated sliding scale insulin coverage at 3 a.m., as follows: 70-120=5 units, 121-160=1 unit. 9/19/12 at 2 a.m., blood sugar was 116 and no coverage was administered, should have been .5	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
units.		The diabetic floresidents blood the range to reinsulin on the fotimes: 9/13/12 at 2 a.m. and no coverage should have be 9/14/12 at 2 a.m. 111 and no coverage should have be 9/15/12 at 2 a.m. and no coverage should have be 9/16/12 at 2 a.m. and no coverage should have be 9/17/12 at 2 a.m. and no coverage should have be 9/17/12 at 2 a.m. and no coverage should have be 9/17/12 at 2 a.m. and no coverage at 3 around the second indicated sliding coverage at 3 around 120=.5 units 9/19/12 at 2 a.m. 116 and no coverage at 3 around 120=.5 units 9/19/12 at 2 a.m. 116 around 120=.	ow sheet indicated the disugar results were in ceive sliding scale ollowing dates and m., blood sugar was 76 ge was administered, een 2 units. m., blood sugar was should have bee an 3 m. blood sugar was 89 ge was administered, een 2 units. m., blood sugar was 72 ge was administered, een 2 units. m., blood sugar was 82 ge was administered, een 2 units. m., blood sugar was 82 ge was administered, een 2 units. rs dated 9/18/12 g scale insulin a.m., as follows: s, 121-160=1 unit. m., blood sugar was werage was			of care services (including providing sliding scale insuling physician orders) to residents the SDC. 4.Residents quality of care was regards to sliding scale insuling orders is randomly observed a monitored daily by the Nursing management team, this is performed through auditing via use of audit tools and daily rounds on unit. Negative resulfrom this monitoring are taken through the Quality Improvement process monthly. Completion date: 12/17/12des	by vith nd l a lts	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWQU11

Facility ID: 012548

If continuation sheet Page 11 of 13

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155790		ULTIPLE CO	NSTRUCTION 00	COME	E SURVEY PLETED 14/2012
		133790	B. WIN				+/2012
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COL CAREY RD	DE	
KINDREI	O TRANSITIONAL (CARE AND REHAB-BRIDGEWA	ΓER		L, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
TAG		m., blood sugar was 99		TAG	DLI ICILIACI)		DATE
		ge was administered,					
	should have be	-					
		m., blood sugar was 85					
	and no coverage was administered, should have been 1 unit.						
	Physician orders dated 10/10/12						
	_	a.m., sliding scale					
		e was 70-120=1 unit,					
	_						
	121-160= 1.5 units, >160 give 1.5						
	units and sliding scale insulin.						
		i.m., blood sugar was					
	85 and no cove	•					
		should have been 1					
	unit.	blandaman					
		ı.m., blood sugar was					
	146 and no cov	•					
		should have been 1.5					
	unit.						
		i.m., blood sugar was					
	181 and no cov	•					
	·	should have been 1.5					
	units and the s	liding scale coverage.					
	On 12/3/12 at ²	10 a.m., additional					
	information wa	s requested from the					
	Director of Nur	sing regarding the					
	above lack of	administration of the					
	sliding scale in	sulin coverage as					
	ordered.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWQU11

Facility ID: 012548

If continuation sheet Page 12 of 13

PRINTED: 01/09/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155790		A. BUILDING B. WING		COMPLETED 12/04/2012		
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	On 12/3/12 at 10:50 a.m., during an interview with the Director of Nursing she indicated she had no additional information to provide regarding the administration of the sliding scale insulin. This federal tag relates to complaint IN00118496. 3.1-37(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VWQU11

Facility ID: 012548

If continuation sheet

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